

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER:  <b>04-13</b>	2. STATE:  <b>TEXAS</b>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: <b>July 1, 2004</b>	
5. TYPE OF PLAN MATERIAL (Circle One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)		
6. FEDERAL STATUTE/REGULATION CITATION: <b>Title XIX Social Security Act, as amended</b>	7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 04      \$ 0 b. FFY 05      \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>SEE ATTACHMENT</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>SEE ATTACHMENT</b>	
10. SUBJECT OF AMENDMENT:  This amendment modifies the enhanced direct care staff rate to give nursing facility providers participating in the direct care staff enhancement program greater flexibility in meeting their staffing requirements with staff time or increased staff wages and/or benefits and to make the distribution of enhancement levels among nursing facilities more equitable. It also modifies the method used to determine the interim rate for state veterans homes.		
11. GOVERNOR'S REVIEW (Check One):  <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Sent to Governor's Office this date. Comments, if any, will be <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      forwarded upon receipt.		
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:  <b>David J. Balland</b> <b>Interim State Medicaid/CHIP Director</b> <b>Post Office Box 13247</b> <b>Austin, Texas 78711</b>	
13. TYPED NAME: <b>David J. Balland</b>		
14. TITLE: <b>Interim State Medicaid/CHIP Director</b>		
15. DATE SUBMITTED: <b>July 26, 2004</b>		
<b>FOR REGIONAL OFFICE USE ONLY</b>		
17. DATE RECEIVED:  <b>AUG - 2 2004</b>	18. DATE APPROVED:  <i>August 17, 2004</i>	
PLAN APPROVED - ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:  <b>JUL - 1 2004</b>	20. SIGNATURE OF REGIONAL OFFICIAL:  <i>Dennis G Smith</i>	
21. TYPED NAME:  <b>Dennis G Smith</b>	22. TITLE:  <b>Director, CMSO</b>	
23. REMARKS:		

## (VI) Direct Care Staff Rate Component.

- (A) Direct care staff cost center. This cost center will include compensation for employee and contract labor Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), medication aides, and nurse aides performing nursing-related duties for Medicaid-contracted beds. For facilities receiving supplemental reimbursement for ventilator-dependent residents or children with tracheostomies, this cost center also includes compensation for employee and contract labor registered Respiratory Therapists and certified Respiratory Therapy Technicians. Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess.
- (B) Rate year. The standard rate year begins on the first day of September and ends on the last day of August of the following year.
- (C) Enrollment. An initial enrollment contract amendment is required from each facility choosing to participate in the enhanced direct care staff rate.
- (1) Participating and nonparticipating facilities may request to modify their enrollment status during any open enrollment period. Nonparticipants and participants requesting to increase their enrollment levels will be limited to requesting increases of three or fewer enhancement levels during any single open enrollment period unless such limits are waived by HHSC. Enrollment will begin on the first day of July and end on the last day of that same July preceding the rate year for which payments are being determined, unless HHSC notified facilities prior to the first day of July that the open enrollment has been postponed or canceled. Should conditions warrant, additional enrollment periods may be conducted during a rate year. Facilities which do not submit an enrollment contract amendment by the last day of the open enrollment period will continue at the level of participation of the previous year within available funds until the facility notifies HHSC that it no longer wishes to participate or until the facility's enrollment is limited in accordance with (VI)(C)(2).
  - (2) A facility will not be enrolled in the enhanced direct care staff rate at a level higher than the level it achieved on its most recently available, audited Staffing and Compensation Report. A facility may request a revision of its enrollment limitation if the facility's most recently available, audited Staffing and Compensation Report does not represent its current staffing levels.
  - (3) At no time will a facility be allowed to enroll in the enhancement program at a level higher than its current level of enrollment plus three additional levels unless otherwise instructed by HHSC.

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- (D) Determination of staffing requirements for participants. Facilities choosing to participate in the Enhanced Direct Care Staff Rate agree to maintain certain direct care staffing levels above the minimum staffing levels described in (VI)(D)(1). In order to permit facilities the flexibility to substitute RN, LVN and aide (medication aide and nurse aide) staff resources and, at the same time, comply with an overall nursing staff requirement, total nursing staff requirements are expressed in terms of LVN-equivalent minutes. The most recent available, reliable relative compensation levels for RNs, LVNs, and aides in Texas NFs, including salaries, wages, payroll taxes and benefits, are used to convert RN and aide minutes into LVN-equivalent minutes. For example, if the most recent available, reliable relative compensation levels for RNs, LVNs, and aides were \$0.42, \$0.28, and \$0.14 per minute respectively, one minute of LVN time would be equivalent to 0.67 minutes of RN time ( $\$0.28 / \$0.42 = 0.67$ ), and to two minutes of aide time ( $\$0.28 / \$0.14 = 2.00$ ). Conversely, one minute of RN time would be equivalent to 1.5 minutes of LVN time ( $\$0.42 / \$0.28 = 1.5$ ), and one minute of aide time would be equivalent to 0.5 minutes of LVN time ( $\$0.14 / \$0.28 = 0.5$ ).
- (1) Minimum staffing levels. For each participating facility, determine a minimum LVN-equivalent staffing level as follows:
- (a) Determine minimum required LVN-equivalent minutes per resident day of service for various types of residents using time study data, cost report information, and other appropriate data sources.
    - (i) Determine LVN-equivalent minutes associated with Medicare residents based on the data sources from (VI)(D)(1)(a) adjusted for estimated acuity differences between Medicare and Medicaid residents.
    - (ii) Determine minimum required LVN-equivalent minutes per resident day of service associated with each Texas Index for Level of Effort (TILE) case mix group and additional minimum required minutes for residents reimbursed under the TILE system who also qualify for supplemental reimbursement for ventilator care or pediatric tracheostomy care. These minimum required minutes are determined using the data sources from (VI)(D)(1)(a) adjusted for acuity differences between Medicare and Medicaid residents and other factors.
  - (b) Based on most recently available, reliable utilization data, determine for each facility the total days of service by TILE group, days of service provided to TILE residents qualifying for Medicaid supplemental reimbursement for ventilator or tracheostomy care, total days of service for Medicare Part A residents in Medicaid contracted beds, and total days of service for all other residents in Medicaid contracted beds.
  - (c) Multiply the minimum required LVN-equivalent minutes for each TILE group and supplemental TILE reimbursement group from (VI)(D)(1)(a) by the facility's Medicaid days of service in each TILE group and supplemental TILE reimbursement group from (VI)(D)(1)(b) and sum the products.
  - (d) Multiply the minimum required LVN-equivalent minutes for Medicare residents by the facility's Medicare Part A days of service in Medicaid contracted beds.
  - (e) Divide the sum from (VI)(D)(1)(c) by the facility's total Medicaid days of service, with a day of service for a Medicaid TILE recipient who also qualifies for a supplemental TILE reimbursement counted as one day of service, compare this result to the minimum required LVN-equivalent minutes for a TILE 207 and multiply the lower of these two figures by the facility's other resident days of service in Medicaid contracted beds.
  - (f) Sum the results of (VI)(D)(1)(c), (d), and (e), divide the sum by the facility's total days of service in Medicaid contracted beds, with a day of service for a Medicaid TILE recipient who also qualifies for a supplemental TILE reimbursement counted as one day of service. The result of these calculations is the minimum LVN-equivalent minutes per resident day the participating facility must provide.

- (2) Enhanced staffing levels. Facilities desiring to participate in the enhanced direct care staff rate are required to staff above the minimum requirements from (VI)(D)(1). These facilities may request LVN-equivalent staffing enhancements from an array of LVN-equivalent enhanced staffing options and associated add-on payments during enrollment. Enhanced staffing options offered are based upon multiples of one LVN-equivalent minute.
- (3) Granting of staffing enhancements. All requested enhancements are divided into two groups after applying any enrollment limitations from (VI)(C): pre-existing enhancements that facilities request to carry over from the prior year and newly requested enhancements. Newly requested enhancements may be enhancements requested by facilities that were nonparticipants in the prior year or by facilities that were participants in the prior year desiring to be granted additional enhancements. Using the process described herein, the distribution of pre-existing enhancements is determined. If funds are available after the distribution of pre-existing enhancements, the distribution of newly requested enhancements is determined:
- (a) For each enhancement option, projected Medicaid units of service for facilities requesting that option are determined and multiplied by the rate add-on associated with the option as determined in (VI)(F)(2).
  - (b) The sum of the products from subparagraph (VI)(D)(3)(a) is compared to available funds.
  - (c) If the product is less than or equal to available funds, all requested enhancements are granted.
  - (d) If the product is greater than available funds, enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds.

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(G) Staffing requirements for participating facilities. Each participating facility will be required to maintain adjusted LVN equivalent minutes equal to those determined in (VI)(D). Each participating facility's adjusted LVN equivalent minutes maintained during the reporting period will be determined as follows:

- (1) Determine unadjusted LVN equivalent minutes maintained. Using facility-specific staffing and spending information, HHSC will determine the unadjusted LVN equivalent minutes maintained by each facility during the reporting period.
- (2) Determine adjusted LVN equivalent minutes maintained. Compare the unadjusted LVN equivalent minutes maintained by the facility during the reporting period from (VI)(G)(1) to the LVN equivalent minutes required of the facility as determined in (VI)(D). The adjusted LVN equivalent minutes are determined as follows:

- (a) If the number of unadjusted LVN equivalent minutes maintained by the facility during the reporting period is greater than or equal to the number of LVN equivalent minutes required of the facility or less than the minimum LVN equivalent minutes required for participation as determined in (VI)(D)(1), the facility's adjusted LVN equivalent minutes maintained is equal to its unadjusted LVN equivalent minutes; or
- (b) If the number of unadjusted LVN equivalent minutes maintained by the facility during the reporting period is less than the number of LVN equivalent minutes required of the facility, but greater than or equal to the minimum LVN equivalent minutes required for participation as determined in (VI)(D)(1); the following steps are performed.
  - (i) Determine what the facility's accrued Medicaid fee-for-service revenue for the reporting period would have been if their staffing requirement had been set at a level consistent with the highest LVN equivalent minutes that the facility actually maintained.
  - (ii) Determine the facility's adjusted accrued revenue by multiplying the accrued revenue from (VI)(G)(2)(b)(i) by .85.
  - (iii) Determine the facility's accrued allowable Medicaid fee-for-service direct care staff expenses for the rate year.
  - (iv) Determine the facility's direct care spending surplus for the reporting period by subtracting the facility's adjusted accrued direct care revenue from (VI)(G)(2)(b)(ii) from the facility's accrued allowable direct care expenses from (VI)(G)(2)(b)(iii).
  - (v) If the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) is less than or equal to zero, the facility's adjusted LVN equivalent minutes maintained is equal to the unadjusted LVN equivalent minutes maintained as calculated in (VI)(G)(1).
  - (vi) If the facility's direct Care spending surplus from (VI)(G)(2)(b)(iv) is greater than zero, the adjusted LVN-equivalent minutes maintained by the facility during the reporting period is set equal to the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) divided by the per diem enhancement add-on for one LVN equivalent minute as determined in (VI)(F) plus the unadjusted LVN equivalent minutes maintained by the facility during the reporting period from (VI)(G)(1) according to the following formula:

(Direct Care Spending Surplus / Per Diem Enhancement Add-on for One LVN Equivalent Minute)  
+ Unadjusted LVN Equivalent Minutes.

- (c) For adjusted LVN equivalent minutes calculated on or after March 1, 2004, requirements relating to the minimum LVN equivalent minutes required for participation in (VI)(G)(2)(a) and (b) do not apply.

- (H) **Staffing accountability.** Participating facilities will be responsible for maintaining the staffing levels determined in (VI)(D). HHSC will determine the adjusted LVN equivalent minutes maintained by each facility during the reporting period by the method described in (VI)(G). Participating facilities that fail to maintain staffing at their required level will have their direct care staff rates and staffing requirements adjusted to a level consistent with the highest staffing level that they actually attained and all direct care staff revenues associated with unmet staffing goals will be recouped by HHSC or its designee.
- (I) **Spending requirements for participants.** Participating facilities are subject to a direct care staff spending requirement with recoupment calculated as follows:
- (1) At the end of the rate year, a spending floor will be calculated by multiplying accrued Medicaid fee-for-service direct care staff revenues by 0.85.
  - (2) Accrued allowable Medicaid direct care staff fee-for-service expenses for the rate year will be compared to the spending floor from (VI)(I)(1). HHSC or its designee will recoup the difference between the spending floor and accrued allowable Medicaid direct care staff fee-for-service expenses from facilities whose Medicaid direct care staff spending is less than their spending floor.
  - (3) Upon request from a parent company, sole member or governmental body that controls more than one nursing facility contract, HHSC will evaluate the contract's compliance with the spending requirements in the aggregate for all contracts that the parent company, sole member or governmental body it controlled at the end of the rate year or at the effective date of the change of ownership or termination of its last nursing facility contract.
  - (4) At no time will a participating facility's direct care rates after spending recoupment be less than the direct care base rates.

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- (K) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes NF nursing care to a Medicaid recipient, DHS makes payment to the hospital using the same procedures, the same case-mix methodology and the same TILE rates that HHSC authorizes for reimbursing NFs receiving the direct care base rate with no enhancement levels. These hospitals are not subject to the staffing and spending requirements.
- (L) Reinvestment. HHSC will reinvest recouped funds in the enhanced direct care staff rate program.
- (1) Identifying qualifying facilities. Facilities meeting the following criteria during the most recent completed reporting period are qualifying facilities for reinvestment purposes.
- (a) The facility was a participant in the enhanced direct care staff rate.
  - (b) The facility's unadjusted LVN equivalent minutes as determined in (VI)(G)(1) were greater than the number of LVN minutes required of the facility as determined in (VI)(D).
  - (c) The facility met its spending requirement as determined in (VI)(I).
  - (d) An acceptable Staffing and Compensation Report was received at least 30 days prior to the date distribution of funds was determined.
  - (e) The DHS contract that was in effect for the facility during the reinvestment reporting period is still in effect as an active contract when reinvestment is determined or, in cases where a change of ownership has occurred, DHS has approved a Successor Liability Agreement between the contract in effect during the reinvestment reporting period and the contract in effect when reinvestment is determined.
- (2) Distribution of available reinvestment funds. Available funds are distributed as described below.
- (a) HHSC determines units of service provided during the most recent completed reporting period by qualifying facilities achieving, with unadjusted LVN-equivalent minutes as determined in (VI)(G)(1), each enhancement option above the enhancement option awarded to the facility during the reporting period and multiplies this number by the rate add-on associated with that enhancement in effect during the reporting period.
  - (b) HHSC compares the sum of the products from (VI)(L)(2)(a) to funds available for reinvestment.
    - (i) If the product is less than or equal to available funds, all achieved enhancements for qualifying facilities are retroactively awarded for the reporting period.
    - (ii) If the product is greater than available funds, retroactive enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until achieved enhancements are granted within available funds.

## VII. Reimbursement Rates for State Veterans Homes

(a) The following definitions apply to this section:

(1) "State veterans home" means a nursing facility as defined in Title 40, Texas Administrative Code (T.A.C.) §176.1 (relating to Veterans Homes Definitions) that is contracted with the Texas Department of Human Services (DHS) to provide nursing facility services to eligible Medicaid recipients who reside in a state veterans home.

(2) "Rate period" means the state fiscal year.

(3) "VLB" means the Veterans Land Board, the state administrative agency to establish and operate state veterans homes.

(4) "DHS" means the Texas Department of Human Services, the state administrative agency authorized to contract for nursing facility services to Medicaid recipients.

(5) "HHSC" means the Health and Human Services Commission, the state administrative agency authorized to adopt standards and rules to govern reimbursement rates and methodologies for Medicaid nursing facility services.

(b) DHS will reimburse the VLB for nursing facility services provided by the VLB to Medicaid clients in state veterans homes.

(c) HHSC determines reimbursement rates for state veterans homes to provide nursing facility services.

(d) Interim reimbursement rates for state veterans homes are prospectively determined for each home based on the state veterans home semi-private room basic daily rate in effect on the first day of the rate period. Rates are retrospectively reconciled based upon actual costs in accordance with subsection (j) of this section.

(e) The facility-specific payment rate from subsection (d) of this section will be paid for all Medicaid eligible residents of a state veterans home regardless of the Texas Index for Level of Effort (TILE) level of the resident.

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(f) Veterans Administration (VA) per diem payments to the VLB for nursing home care as defined in 38 Code of Federal Regulations (CFR) §51.40 (relating to monthly payment) is considered third-party resources. These payments will be offset against per diem payment rates for Medicaid eligible residents of a state veterans home.

(g) Residents of the state veterans home will not be eligible to receive the supplemental reimbursements for ventilator-dependent residents and for children with tracheostomies (as described in (IV)(B)(5) and (IV)(g) above).

(h) State veterans homes are not eligible to participate in the Enhanced Direct Care Staff Rate or the Performance-based Add-on Payment Program (as described in (VI) and (VII) above).

(i) The VLB will submit financial and statistical information in a format designated by HHSC. This information may be reviewed or audited in accordance with (II)(C) above. Financial and statistical information submitted by the VLB will not be included in the cost report databases used in the reimbursement determination process for the Texas Medicaid NF program.

(j) For each state veterans home, the interim reimbursement rate is adjusted retrospectively based upon actual costs accrued during the rate period.

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